TESTIMONY TO THE INTEGRATED HEALTH CARE DELIVERY MODELS AND MULTI-PAYER DELIVERY SYSTEMS STUDY COMMITTEE

Key Points on Developing Effective, Integrated Services for Young Children and their Families to Ensure Healthy Development

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For this presentation, CFPC provides key points relevant to developing Iowa policies and practices to improve children's healthy development.

1. If Iowa wants to be the healthiest state in the nation, it must raise the healthiest children.

Efforts to boost healthy development must recognize the changing face of Iowa's children, who are much more diverse than Iowa adults. Children—young children in particular—also represent the age group most likely to be in poverty and struggling to meet basic needs. Although many children are doing better than ever before, there are huge challenges related to child health, including food security and obesity and exposure to toxic environments.

2. From a prevention perspective, health practitioners can play their greatest role in the first years of life, but more as first responders than all-inclusive service providers.

In large measure due to public policy efforts to expand child health coverage under Medicaid and *hawk-i*, almost all young children in Iowa (approximately 96 percent) are covered, and more than 90 percent have at least one well-child visits—and most a number of visits—through these years to check developmental progress. Meanwhile, fewer than 15 percent of young children are in formal child care arrangements. That means the health practitioner is the only near-universal point of contact with children in early years. Therefore, the practitioner is in the best position not only to address medical issues, but also to identify children whose health may be jeopardized because of their home and neighborhood environments—in effect, serving as a "first responder" to the many factors that affect children's healthy development.

3. This requires an integrated approach that goes beyond clinical care to address social determinants of health (toxic stress, ACEs, etc.)

The growing research base on child health and development emphasizes the critical role of the first years of life in setting a healthy trajectory, and the adverse impacts on health of early-childhood adversity and toxic stress. Practitioners can identify children at risk of troubles, but responding to this risk requires connecting families with services beyond clinical care. It involves strengthening protective factors within families, which generally requires skilled care coordination outside the practitioner's office to help connect children with community resources (going beyond referrals to scheduling and follow-up).

4. The potential return on investment is huge, but it is not short term and does not necessarily fit into current contracting models to meet the triple aim.

Young children, in general, are not drivers of short-term health care costs, but their health trajectories have huge consequences on future health and the chronic conditions that drive health care costs. Emphases on accountable care organizations and contracting provisions that seek to meet the triple aim easily can be designed in ways where little intention is given to young children and, if anything, the incentives move away from providing comprehensive and integrated care. While improving the health of young

children may have the greatest impact on lowering per-capita health costs in the long-term, this does not fit into short-term contracts predicated on securing cost savings. Instead, up-front investments are needed (potentially financed in part through the shared-savings received from shorter-term efforts). Some of the savings will be in medical care, but some will be in improved social and educational outcomes.

5. Iowa needs to offer incentives and supports to champions in the field to adopt and spread evidence-based practices.

Fortunately, Iowa has a growing number of exemplary practices and champions in the field who can spread their experiences to peers. This includes the 1st Five Initiative, Project LAUNCH, and many reforms within Medicaid to cover developmental services under the Assuring Better Child Health and Development (ABCD) Initiative. Iowa is a participant in both the National Improvement Partnership Network and the Help Me Grow Network. This places Iowa at the forefront of states in this work, but much more needs to be done. The field is at the stage of innovators and very early adopters of new, more integrated and comprehensive primary-care approaches.

6. Medicaid play a key, but not the only, role.

Currently, more than half of all Iowa children birth to three are covered by Medicaid. They average over two well-child/EPSDT visits per year, which provides great opportunity to respond to both medical and social determinants of health. When looking at children who are most vulnerable to early-childhood adversity and toxic stress, it is estimated that Medicaid serves over 70 percent of them. Remaining children are most often covered by private health plans, and work needs to be done to promote alignment of practices (particularly reimbursement for developmental screening) in those plans.

7. Iowa is positioned to take next leadership steps.

1st Five plays a key role in promoting primary care practices and linking families to services through care coordination, but is not yet statewide or comprehensive in its scope. Continued expansion, coupled with continuous learning to identify opportunities for more integrated services, should continue.

One identified need is to ensure that children at highest risk of toxic stress receive the services they need. This often goes beyond care coordination to specific initial two-generational approaches, through both intensive home visiting (e.g. Child FIRST) and center- and group-based care. Another need is behavioral health services.

As such approaches expand, the adequacy of community services and supports, including home visiting, family support and parent education programs as well as professional services, needs to be examined.

Iowa has an opportunity to foster continued development through its State Innovation in Medicaid (SIMs) program follow-up grants – particularly by focusing on comprehensive approaches to young children within Medicaid by using some of the federal funding available for new approaches specifically to promote innovation and early adoption. Iowa also can set out some set-aside from any shared-savings in its general ACO and ACO-like contracts for reinvestment in young children, where ROIs are longer-term.

In addition, Iowa can work to secure financing under Medicaid for at least some array of home visiting programs, like Child FIRST, that promote healthier child development—doing so in ways that are consistent with their programmatic approaches.

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CFPC has a number of resource materials, including demographic and service information and information on evidence-based approaches in Iowa and around the U.S., that expand on each of the above points. Contact Danielle Oswald-Thole at danielleot@cfpciowa.org or Mary Nelle Trefz at mnt@cfpciowa.org to learn more.